1. **Q: What is the appropriate date of service for enteral nutrition? Is it the date of delivery or patient usage dates?**

A: Per the Centers for Medicare and Medicaid Services (CMS) Program Integrity Manual (PIM), in instances where the supplies are delivered directly by the supplier, the date the beneficiary received the Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) shall be the date of service on the claim. "If a supplier utilizes a shipping service or mail order, suppliers shall use the shipping date as the date of service on the claim." There is no exception specific to enteral products.

2. **Q: Please discuss the issue of requiring physician oversight for certain DMEPOS items/services where the Local Coverage Determination (LCD) does not state this requirement.**

A: For any DMEPOS item to be covered by Medicare, the patient’s medical record must contain sufficient documentation of the patient’s medical condition to substantiate the necessity for the type and quantity of items ordered and for the frequency of use or replacement (if applicable). The information should include the patient’s diagnosis and other pertinent information including, but not limited to, duration of the patient’s condition, clinical course (worsening or improvement), prognosis, nature and extent of functional limitations, other therapeutic interventions and results, past experience with related items, etc.” It is expected that the patient’s medical records will reflect the need for the care provided. The patient’s medical records include the physician’s office records, hospital records, nursing home records, home health agency records, records from other healthcare professionals and test reports. This documentation must be available upon request.”

3. **Q: How are DME services targeted for CERT?**

A: All Medicare providers and suppliers (inpatient facilities, hospitals, skilled nursing facilities, home health agencies, physicians, outpatient services and DMEPOS suppliers) are subject to a random CERT review.

4. **Q: For overnight oximetrys, is the face sheet indicating the sum of all of the testing results sufficient or must we have the actual graphs? The referral sources always give us a hard time with this.**
A: A Face Sheet (like a CMN or DIF) must have its information supported by actual clinical records, such as the actual copy of the report, or the studies documented within the doctor’s or nurse’s notes. "However, neither a physician’s order nor a CMN nor a supplier-prepared statement nor a physician attestation by itself provides sufficient documentation of medical necessity, even though it is signed by the treating physician. There must be clinical information in the patient’s medical record that supports the medical necessity for the item and substantiates the answers on the CMN (if applicable), or information on a supplier-prepared statement or physician attestation (if applicable).

5. **Q:** What specific documentation are you looking for on the annual physician’s visit? Can we compose a form that is included in the visit record that the physician would complete?

A: Specific documentation in an annual doctor’s visit depends on the item(s) being billed. Documentation must cite the medical necessity of the items as indicated within the specific policies listing the medical necessity of the coverage criteria. You are not prohibited from creating a form for screening purposes; however, any information contained on the form must be substantiated by comprehensive information in the medical records.

6. **Q:** Why are CERT documentation requests seemingly more stringent than the corresponding LCD?

A: CERT documentation requests may seem to be more stringent due to the fact that not only are the LCD’s being taken into consideration but also ALL applicable CMS manuals and regulations are being considered.

7. **Q:** For oxygen patients we are having a difficult time with the physicians not performing actual oximetry or ABG tests. Most physicians are just doing pulse oximetry tests in the office. Is this acceptable?

A: Yes, as long as the test meets all the policy requirements.

8. **Q:** If a supplier leaves some emergency enteral supplies in a SNF for late admissions or physician order changes, what date of service do we use on the claim since there is not a delivery/shipping date? Can a delivery ticket detailing the resident it is dispensed to and a date is created to dispense emergency Part B enteral supplies in long-term-care?
A: In chapter 4 of the PIM, it does state "For those patients that are residents of a nursing facility, upon request from the DME MAC, suppliers should obtain copies of the necessary documentation from the nursing facility to document proof of delivery or usage by the beneficiary (e.g., nurse’s notes).

9. Q: Manufacturers of enteral supplies do not recommend breaking cases to ship supplies because they can be damaged or contaminated. If a resident requires 30 bottles of enteral nutrition for the month and there are 8 bottles per case, this leaves 2 extra bottles. In 4 months, we eventually ship a case less because the beneficiary has the extra, how does the supplier get paid for the products they have provided up to 4 months ago? How do we prove this in a post-pay audit since the shipping date for the extra supplies is more than 5 days prior to the usage date?

A: It is recommended by the manufacturer to not break up cases; however, this is not a requirement. Per Medicare guidelines and regulations, suppliers should only bill and supply what the patient is actually using. Suppliers are reminded that you are only able to bill up to a one month supply at a time.

10. Q: What specific documentation is needed in suppliers' files for oxygen patients? Are specific oxygen test results needed in suppliers' files? How do suppliers document that the patient has been re-seen by their physician?

A: The file should contain, the written physician order, initial & recertification (if applicable) CMNs, copy of study results report, clinical evaluation/ re-evaluation (if applicable) and clinical records to support information stated in the CMNs, and ongoing documentation of the medical management of the patient’s oxygen use in the patient’s record. You must have access to specific oxygen test results (a copy of the actual study) in case of an audit, you can reference the oxygen LCD for these testing requirements. Suppliers may include chart notes proving that the patient has been seen and reevaluated in the required timeframe according to the LCD.

11. Q: What exactly does the supplier need to do to verify the signature of the treating physician in the case of a CERT audit?

A: CERT will accept an attestation letter of signature verification. CERT will also use other records submitted to attempt to match the illegible signature.
12. **Q:** Are you going to start to adhere to legible doctor signatures when deciding to accept/not accept medical documentation?

   **A:** Yes.

13. **Q:** Our National Company has a billing center and sometimes there are problems with the distribution sites receiving the CERT request. Is there a way to make sure the billing center receives the request?

   **A:** A point of contact may be established with CERT. When calling the CERT contractor to confirm updated contact information, please ensure to have your DME MAC Contractor number ready.

14. **Q:** Why do claims still deny for medical necessity even though the CERT audits are answered? Why do the same patients get picked for CERT audits over and over?

   **A:** Submitting medical records to CERT does not guarantee that they support the medical necessity for coverage criteria of the items billed. For example, a progress note sent may not contain the information necessary to meet an item’s coverage criteria needed for the item. CERT selects claims randomly. The more claims a supplier submits, the higher the probability that a supplier’s claim may get chosen.

15. **Q:** Does there need to be a specific number of refills on a prescription/order for diabetic supplies, or can they get the appropriate quantity (every 30 days or 3 months) for up to 12 months from the prescription date, after which a new prescription is required?

   **A:** The prescription/order is valid for what the doctor prescribes, i.e. one month, 6 months, 12 months or lifetime, unless a policy specifies a specific time when a new order is required.

16. **Q:** When a person comes in with an appropriate prescription with diagnosis on it for DME (i.e., manual wheelchair, or semi-electric bed), can we call the ordering physician to ask the duration of need and document it on prescription? Do we have the beneficiary sign the ABN indicating the reasons the DME may not be covered per LCD? Do we not give the DME to the
person until we get the required medical documentation (week/month) to ensure we will be paid and not have money taken back if we were audited because the person was not eligible?

A: Based on the initial order, suppliers can complete and send back to the physician to sign off on. The ABN must be provided prior to delivery of the item and suppliers would need to have knowledge if the patient does or does not meet medical necessity prior to having them sign the ABN.

18. Q: How should we handle requests for documents that are not a requirement of the LCD?

A: CERT asks for documentation beyond what is listed in the LCD. They also ask for information from CMS Manuals and regulations.

19. Q: Please explain the “Specialty Evaluation" and whether it includes ALL accessories to a power wheelchair.

A: The “Specialty Evaluation” is typically completed by a physical therapist (PT) or occupational therapist (OT) specializing in power wheelchairs. The evaluation should be a written document providing information on how the power options (such as; power tilt or recline) will address and aide the patient’s mobility limitations as well as any other added feature to the basic power wheelchair.

20. Q: What documentation is needed for intermittent use of inotrope drugs on an E0781 ambulatory infusion pump?

A: The documentation needed would be a written order, physician records pertaining to the information as outlined in the Local Coverage Determination (LCD) and Policy Article including the before and after inotropic drug infusion values, request for refill, and proof of delivery.

21. Q: What is the supplier's responsibility for monitoring oxygen use? If patients are not using the oxygen for the hours prescribed, what is the supplier's responsibility regarding informing the prescribning physician?

A: We are all responsible for doing our part to protect the Medicare Trust Fund by ensuring that claims submitted to the Medicare Program for reimbursement meet the Medicare coverage criteria. If a supplier is aware
that a beneficiary is not using oxygen for the hours prescribed, or that the beneficiary no longer meets medical necessity criteria, the supplier should inform the ordering physician. If the supplier is aware that the coverage criteria are not met, the supplier should not submit a claim to the Medicare program for payment.

22. **Q:** If the patient is not using oxygen, but still has saturation levels at rest of less than 89%, and the physician refuses to certify that the patient does not require oxygen, what is the supplier's responsibility for continuing to supply and bill for oxygen?

A: If the supplier is aware that the coverage criteria are not met, the supplier should not submit a claim to the Medicare program for payment. In the case of items which require a discontinue order from the ordering physician and the ordering physician does not find it in the patient’s best interest to discontinue the item, suppliers should execute an ABN advising the patient of his or her financial liability for the items/services.

23. **Q:** What specific documents are you looking for when auditing a CPAP claim?

A: If the claim is for the first through third month(s) then initial coverage criteria would need to be met with the following documentation provided: written order, qualifying sleep study, documentation regarding the initial face to face examination, and proof of delivery. If the claim is for fourth and subsequent months, the supplier must provide initial coverage criteria documentation plus documentation regarding meeting compliance as outlined in the LCD, re-evaluation, and continued use of the equipment or supplies (request for refill).

24. **Q:** What do supplier’s look for in physician records to support over-utilization for diabetic testing supplies? If patients are not testing their blood sugars, should they be eligible for diabetic shoes and inserts?

A: The physician records regarding supporting over-utilization for diabetic supplies should describe the patient’s symptoms requiring an increase in testing frequency, how long they feel the patient will need to test at a higher frequency, what the patient’s blood sugar readings are and changes being made with their diabetes management, and when their last HGB A1C and results was. Diabetic shoes and inserts are eligible for coverage if the patient has documented diabetes mellitus and meet one or more of the conditions as outlined in the local coverage
determination (LCD) and policy article documented in the medical records by the certifying physician.

25. **Q:** What clinical documents are necessary to make a file complete for diabetic supplies, especially if a diabetic patient is not insulin dependent and provides a prescription written from M.D. for testing more than once a day.

   A: The documentation that should be provided if requested for a non-insulin dependent diabetic testing above the typical allowed amount (once per day) would include; written order, physician progress notes regarding the patient’s condition and need for testing above the allowed amount, patient’s testing log showing they are in fact testing the prescribed amount of times, request for refill, and proof of delivery.

26. **Q:** How do you begin approaching the physician with the request to obtain the copies of his clinical notes especially now that everybody is concerned with HIPAA?

   A: It is not against HIPAA law for physicians to provide suppliers with the medical record documentation to help support the need for their claims. Each of the four DME MAC Jurisdictions have documents available on their websites (such as the “Dear Physician” letters) to educate and help obtain the necessary documentation from the physician.

27. **Q:** We have a lot of issues with patients not seeing their physician in several years and the physician is not able to provide medical records. We spend endless hours trying to obtain documentation, but are at a loss providing these records to CERT.

   A: This is a business decision on the supplier’s part whether to obtain the supporting medical documentation up front or to wait until a request is received. If you wait until a request is received then you are taking a greater chance that you will not be able to obtain the supporting documentation and therefore holding you liable due to coverage criteria not being supported and an not having issued an ABN.

28. **Q:** How can we get doctors to sign their names legibly?
A: We are encouraging suppliers to start sending in signature keys. Some suggestions are having a log with the physicians name printed clearly and then their signature next to it. Also we have heard some suggestions about on the orders having the physician’s name printed clearly underneath his signature.

29. Q: What is acceptable paperwork for the prescription and Detailed Product Description - is there a form that Medicare can provide so everything can be uniform Medical Documentation?

A: Medicare does not provide a document for suppliers to use regarding the written order or the detailed product description but provides what information must be on these documents.

30. Q: What avenues of recourse are there when the physician or physician offices do not respond to the audit documents requests and in fact refuse to collaborate with the suppliers?

A: Currently there is no recourse on the physicians if they do not respond to the Request from CERT regarding a DME supply. Suppliers should refer to the PIM citation Manual 100-8 Chapter 5 section 5.8 which states the following, “the supplier should also obtain as much documentation from the patient’s medical record as they determine they need to assure themselves that coverage criteria for an item have been met. If the information in the patient’s medical record does not adequately support the medical necessity for the item, the supplier is liable for the dollar amount involved unless a properly executed ABN of possible denial has been obtained."

31. Q: Are supplemental insurance required to pay according to how Medicare pays on a Home Sleep Study. We continue to receive denials where the supplemental insurance does not pay and they state it is non-covered even though Medicare found it to be medically necessary.

A: Not all supplemental insurances are considered Medigap policies; therefore they are not required to pay according to Medicare. A Medigap policy is health insurance sold by private insurance companies to fill the "gaps" in Original Medicare Plan coverage. Medigap policies help pay some of the health care costs that the Original Medicare Plan doesn't cover. If a beneficiary has the Original Medicare Plan and has a Medigap policy, then Medicare and the Medigap policy
will each pay its share of covered health care costs. Within each Medigap policy are different levels of coverage.

Suppliers are encouraged to check with the supplemental insurance to determine if it a Medigap policy and to determine the level of coverage the beneficiary has. If the supplemental insurance the beneficiary has is not Medigap, the supplemental insurance is not required to cover the same services as Medicare covers. To report non-compliant Medigap insurances, suppliers should contact your local state insurance department. For additional information on Medigap coverage, please refer to the Centers for Medicare & Medicaid Services Web site: http://www.cms.hhs.gov/Medigap/

32. **Q:** Recent CERT requests related to oxygen have asked for evidence of ongoing medical necessity after the time of the recertification CMN (that is the 2nd CMN signed by the physician as required in the LCD). Why is this, how should the supplier respond and is there basis for claims denial if no further testing or physicians documentation is available?

**A:** Suppliers should be checking on a continual basis with the beneficiary that they are in fact continuing to use the equipment and do need the supplies being provided to them. This would be checking for a “request for refill” which is outlined in the IOM 100-08, chapter 4, section 4.26.1. Some type of documentation regarding either contacting or being contacted by the beneficiary within one week prior to delivery that the beneficiary attests to using the equipment and needing the items and quantities to be delivered.

33. **Q:** Are ABN’s appropriate when certain physicians, or other prescribing providers, have demonstrated they are not willing to provide the requested clinical/medical information to substantiate their prescription?

**A:** The supplier should obtain as much documentation from the patient’s medical record as they determine they need to assure themselves that coverage criteria for an item have been met. If the information in the patient's medical record does not adequately support the medical necessity for the item, the supplier will be held liable for the dollar amount involved unless a properly executed ABN has been obtained. A supplier may not routinely issue ABNs to a particular physician who has a history of not providing the necessary documentation; the supplier may only issue the ABN after the supplier has
attempted to obtain the necessary documentation and failed, and/or the documentation received does not support medical necessity.

34. **Q:** Why are suppliers being asked to provide medical records beyond the scope of what is outlined in the specific LCDs? Why are physicians and beneficiaries not held responsible for some of the fraud committed in the industry?  

**A:** Suppliers are being asked to supply records in accordance with ALL Medicare Guidelines not just Local Coverage Determination and Policy Article. As it is stated in the PIM 100-8 Chapter 5 Section 5.7 "However, neither a physician’s order nor a CMN nor a DIF nor a supplier prepared statement nor a physician attestation by itself provides sufficient documentation of medical necessity, even though it is signed by the treating physician or supplier. There must be information in the patient’s medical record that supports the medical necessity for the item and substantiates the answers on the CMN (if applicable) or DIF (if applicable) or information on a supplier prepared statement or physician attestation (if applicable)."

35. **Q:** If a recertification CMN overlaps a revised CMN, how is this handled so it does not create a denial for CMNs?  

**A:** When a change occurs that necessitates a revised CMN, and a recertification CMN is also due, the supplier must submit only the recertification CMN.

36. **Q:** What do you do if the MD does will not provide Progress notes? What do you do if the MD provides Progress notes, that are poorly written and do not pertain to the piece of equipment that was ordered and already given by DME.  

**A:** It is the supplier’s responsibility to obtain the documentation needed to support the medical necessity of the equipment being supplied. If the physician does not provide you with the documentation that you request you can explain to them that it is stated in the PIM Chapter 5 Section 5.7 "For any DMEPOS item to be covered by Medicare, the patient’s medical record must contain sufficient documentation of the patient’s medical condition to substantiate the necessity for the type and quantity of items ordered and for the frequency of use or replacement (if applicable). The information should include the patient’s diagnosis and other pertinent information including, but not limited to, duration of the patient’s condition, clinical course (worsening or improvement),
prognosis, nature and extent of functional limitations, other therapeutic interventions and results, past experience with related items, etc” and "There must be information in the patient’s medical record that supports the medical necessity for the item and substantiates the answers on the CMN (if applicable) or DIF (if applicable) or information on a supplier prepared statement or physician attestation (if applicable)”. This is a business decision on the supplier’s part whether to obtain the supporting medical documentation up front or to wait until a request is received. If you wait until a request is received then you are taking a greater chance that you will not be able to obtain the supporting documentation and cannot issue an Advance Beneficiary Notice of Non-coverage at that time holding you liable due to coverage criteria not being supported.

37. **Q:** How long after submitting CERT requested information should we receive a decision?

**A:** Once the CERT review is completed and if CERT has made a denial on your claim the DME MAC will adjust your claim. You will then receive a recoupment letter from the Overpayment Recovery Unit within 30 days.

38. **Q:** Please provide a list of important documentation needed for a Medicare patient on enteral formula with or without pump and supplies.

**A:** Please refer to the Documentation Requirements within the Local Coverage Determination and Policy Article for Enteral Nutrition.

39. **Q:** Does the Assignment of Benefit (AOB) from the patient have to be signed and dated before the date of service?

**A:** AOB must be signed and dated before or on the date of service.

40. **Q:** Could failure to include the KX modifier be a CERT trigger?

**A:** The CERT contractor randomly selects claims for review. Improper use of the KX should not “trigger” a CERT review.

41. **Q:** Can an respiratory therapist (RT) in an oxygen supplier’s office do pulse oximetry spot checks on patients at rest to qualify them for home O2 if they have orders from a physician? Exactly who is considered "qualified" to provide this test?
A: No, a respiratory therapist in a supplier’s office will not qualify a beneficiary for home oxygen under any circumstances. The rules governing who can qualify a patient are governed by the Oxygen and Oxygen Services LCD (L11446) under the "Testing Specifications" section.

42. Q: How do suppliers get reimbursed for oxygen tank delivery? When and how do we bill for maintenance for oxygen patients?

A: Medicare does not pay separately for the delivery of oxygen tanks, since it is included in the supplier’s monthly rental reimbursement during the 36-month rental cap, and it is included in the reimbursement for contents after the 36-month cap is reached. The rules for maintenance and servicing of oxygen equipment for 2010 are outlined in detail in Medicare Learning Network Matters article 6716.

43. Q: Where do I find documentation requirements for diabetic shoes?

A: Documentation requirements for Diabetic Shoes are available in the Therapeutic Shoes for Diabetics LCD (L11525) and Policy Article.

44. Q: Do we need to have a copy of the face-to-face in our patient chart, or will documentation of the date and time be sufficient for billing purposes?

A: If the supplier is referring to Power Mobility devices, yes the face-to-face exam must be in the suppliers’ files.

45. Q: Will LCD/fee schedules list the correct modifiers/HCPC information for providers on January 1, 2010? I understand that as of January 1st, any errors with modifiers will not be able to be corrected through the reopening process anymore. Will Medicare provide correct modifiers/information on website?

A: If supplier is referring to the proper use of the KX modifier, yes information is available on the contractor websites regarding correct usage. Changes have recently been made to several Medicare policies regarding use of the KX, GA, GZ, and GY modifiers. Suppliers should refer to the LCD to determine proper use of those modifiers. For many modifier situations, when the modifiers are incorrectly billed, this may result in a return/reject. For those situations,
suppliers must correct the claim line and resubmit the claim for processing – it is not necessary to go through the reopening process.

46. **Q:** Please provide information specific to filing post operative cataract glasses. How do we properly file for frame and lenses following cataract surgery? Are patients allowed 2 frames if they have surgery on both eyes? Do these benefits expire? Can a patient use their current frame but file for lenses only? What add-ons are allowed or are they all patient responsibility?

**A:** Suppliers are required to have a National Supplier Clearinghouse number and submit claims to the appropriate DME MAC based on where the beneficiary is registered with Social Security. There are statutory limits; one pair of lenses and frames after each cataract surgery. This is not an accumulative benefit. If the beneficiary does not get lenses after the first surgery but waits unit after the second, only one pair is allowed. A patient may use their current frames and only replace the lenses, but frames at a later time will not be allowed. Please refer to the LCD and Policy Article for medically necessary options and how to appropriate bill for them, as well as all general coverage, coding and billing requirements.

47. **Q:** What key elements will the CERT Contractors be addressing during an audit.

**A:** Documentation to support medical necessity and proof that the coverage criteria are met as well as appropriate code guidelines are followed.

48. **Q:** What can be done to get more cooperation from doctors in providing DME companies with sufficient medical documentation so that we may better comply and feel confident that what we have obtained with be enough in case of an audit?

**A:** A vigorous intake process is recommended. Asking the appropriate questions once an order is received based on coverage criteria requirements, begins the documentation process. Partnering with the physician on behalf of the beneficiary is a must. If you are finding that difficult, please refer and utilize one of the many physician letters developed by the DME MAC Medical Directors, which discusses the ordering physician’s roles, and responsibilities required by Medicare law
49. **Q:** Are there any CERT documentation requirements specifically affecting orthotics and prosthetics?

**A:** Documentation requirements are the same regardless of what type of equipment is dispensed.

50. **Q:** How come the date of service in question gets recouped when there is not a doctor’s note on that specific date but the need is still proved by doctor’s notes around that date. What do we do when the doctor refuses to give the notes needed even when we give them the CERT audit and the letter Medicare made for this reason? How come a “pad Rx” is not considered part of the patient’s medical record when the doctor signs it?

**A:** 1. An item cannot be dispensed before the medical need is determined. For example, if the physician documented the need in the beneficiary’s medical record on 1-1-10, the item cannot be dispensed prior to that. 2. Suppliers should assure prior to dispensing an item that the medical records support the medical need and medical records are available upon request. 3. A "pad Rx" is just that, an order. The patient’s medical record includes the ordering physicians patient’s diagnosis and other pertinent information including, but not limited to, duration of the patient’s condition, clinical course (worsening or improvement), prognosis, nature and extent of functional limitations, other therapeutic interventions and results, past experience with related items, etc. The "pad Rx" cannot provide this type of information and is not considered the patient’s medical record.

51. **Q:** How are physicians in the hospital affected by the outcomes of the CERT program in regards to documentation/ordering?

**A:** The DME supplier is expected to know if there is appropriate documentation and a complete order for an item. If a DMEPOS item is dispensed, and a CERT audit is conducted that shows the documentation is not sufficient to support medical necessity, the DME supplier is affected by recoupment, not the ordering physician. The Local Part B and Part A contractors also receive CERT audits that may affect hospitals, and physicians within those hospitals reimbursements.

52. **Q:** Please explain compliance for CPAP documentation both before sleep study and after trial use. What is sufficient from the doctor before sleep study? If chart notes are not detailed, does the DME supplier deny delivery of
CPAP machine to be covered by Medicare even though the sleep study definitely showed a medical need? It is hard for us as a supplier to determine if the medical chart notes are sufficient for an audit.

A: Before the sleep study the beneficiary must have received a face-to-face examination with a treating physician to assess the patient for obstructive sleep apnea. A thorough intake process in recommend to assure all the coverage criteria is met. Asking appropriate questions and gathering medical records prior to dispensing the device allows the supplier to know if coverage criteria is met, if the coverage criteria is not met, the supplier may want to consider executing an ABN to protect themselves from liability.

53. Q: What is included in the error rate calculation? Should entities use this calculation to track error rates? Is the expected error rate always 0%, or up to 5%?

A: The error rate is calculated for the Medicare contractor, not the individual suppliers.

54. Q: Why now do we have to have blood gas done when before it was pulse oximetry or blood gas? Do you have to have a special person to do a power wheelchair that is sold without special seating?

A: In the Oxygen LCD, the term blood gas study includes both an oximetry test and an arterial blood gas test. A Group 2, single power option power wheelchair and above requires the supplier to employ a RESNA-certified Assistive Technology Professional (ATP) who specializes in wheelchairs and who has direct, in-person involvement in the wheelchair selection for the patient.

55. Q: Who is supposed to train a patient on the usage of a glucometer -- the doctor or the supplier? What kind of documentation do we need to keep in patient's file? What can we do if doctors are not willing to send progress notes, lab etc.?

A: Glucometer training can be completed by either the physician or the supplier. However, it is the responsibility of the supplier to ensure the training has been completed to be in compliance with the Glucose Monitors LCD. Per this LCD, the following documentation is required to be in the patient's file and made available upon request: verbal order (if item is dispensed based on a verbal order), written
order, beneficiary authorization, proof of delivery, and documentation supporting the basic coverage criteria. Additional documentation must be included in the patient's medical record including the diagnosis, reason for frequency of testing, physician's evaluation, actual testing frequency, and evidence that the supplies are nearly exhausted prior to refilling the order. Refer to the Glucose Monitor LCD for detailed information. If a supplier is having issues retrieving appropriate documentation from the physician, there is Physician Letters on the DME MAC Web sites to help in the collection of this required documentation.

56. Q: If a beneficiary is at a facility and we get a request for DME items and the beneficiary's address with Medicare is the same as the facility do we indicate the place of service as “home”?

A: If the beneficiary is in an Assisted Living Facility use POS 13, for a Nursing Home use 32. Refer to your Jurisdiction's supplier manual for appropriate POS codes.

57. Q: Prior to all the recent guidance to use ship date versus usage date for our enteral patients we were following the 7 day 5 day rule for contacting patient, however we used the documented next usage cycle as the bill date. For example, we have clear documentation that we have contacted the beneficiary, reviewed their inventory, asked our nutritional support questions to determine compliance, and informed beneficiary that we will be shipping their next month supply tomorrow (within the 5 day window). And it is documented that this shipment is for the next supply period e.g. January 5-February 4th. That is what we used for bill dates versus the current guidance to use the ship date as the bill date. What is our liability in this situation?

A: Date of service is either the ship date if the item is being shipped, or the date the supply was directly delivered to the beneficiary. If it differs, that may cause a CERT error.

58. Q: Why does it take so long to get results from CERT audits? We just received an overpayment request from 18 months ago.

A: The CERT reviews are usually completed within 60 days but after the CMS issued JSM/TDL-09225 dated 03-26-09 CERT was instructed to go back and re-review all of their previous determinations made after the OIG findings were
released. What happened was the OIG (Office of Inspector General) performed quality review on the CERT claim determinations. The OIG findings determined that CERT was not reviewing the claims in accordance with CMS guidelines and regulations therefore claims that had been reviewed more than a year ago where re-reviewed for a determination.

59. **Q:** Could CMS make it as a policy or standard that every person in the DME or like be trained or possess some kind of health related certification or accredited college degree in an area dealing with DME as a provider, or open up a new DME business.

   **A:** All Medicare statutory and regulatory requirements must be followed, to include Quality Standards, Accreditation and Supplier Standards. Supplier Standard # 1 states all applicable Federal and State licensure and regulatory requirements must be met.

60. **Q:** We have gotten requests for documentation that is not listed in the LCD, such as physician follow-up at 6 months when it is not a recertification. How do we deal with these?

   **A:** CERT reviewers will ask for documentation to support the beneficiary is still needing and using the oxygen and is under the physicians care for oxygen. CERT needs to make sure the beneficiary is seeing a physician for their oxygen needs. All LCD’s state in the documentation section:

   Section 1833(e) of the Social Security Act precludes payment to any provider of services unless "there has been furnished such information as may be necessary in order to determine the amounts due such provider". It is expected that the patient's medical records will reflect the need for the care provided. The patient's medical records include the physician's office records, hospital records, nursing home records, home health agency records, records from other healthcare professionals and test reports. This documentation must be available upon request.

61. **Q:** When a doctor writes a prescription knowing that a patient does not qualify for the item prescribed, wouldn’t that be a fraud?

   **A:** This would not be considered fraudulent. Physicians may prescribe an item they believe is necessary for their patient without regard to DME statutes.
62. Is a physician’s assistant (PA) or nurse practitioner (NP) allowed to make corrections to an order signed off on by an MD or DO? How should additional information" or "changes" be documented on an order or chart note? Does it require date and initials or just initials?"

A: No, any corrections to documentation must be made by the physician. A physician must initial and date all corrections.

63. Q: Any suggestions on how we are to retrieve the extra documentation from the doctors.

A: All DME MACs offer resources such as the "Physician Documentation Letter" that can assist suppliers in obtaining medical records.

64. Q: What are the requirements for oxygen?

A: Please refer to the Oxygen LCD (L11446) and Policy Article (A33750).

65. Q: Why are ABN’s not used or recognized by Medicare Fee for Service Insurance? If we cannot use them than what are we to do if our customer wishes to upgrade? Do they not have that right as a Fee for Service customer?

A: ABN's are used for Fee-for-Service Medicare. You can locate ABN information on the CMS Web site and each DME MAC website.

66. Q: What is CERT looking for in physician’s progress notes? What date range of progress notes is CERT looking for?

A: Physician progress notes must support that the criteria outlined in the LCD are met. The date range would vary depending on the dates of service in the CERT request.

67. Q: Are there any direct changes affecting the Post/op Rx glasses?

A: No.
68. **Q:** It has been under our impression that our detail order which had the same as the 7 element order was ok. But now we are being denied because we don't have a separate 7 element order. When did the 7 element order take place?

**A:** The 7 element order was required as of 05/05/05 which was included in the archived motorized/power wheelchair base LCD. The Physician or PT/OT is able to complete the MRADL’s but the treating physician must still sign off on these results.

69. **Q:** We have a terrible time getting physicians to respond to our requests for documentation. When they do respond, it is never with the documentation we have specifically asked for.

**A:** Since the provider receives payment for the item dispensed, it is up to the provider to be sure they have or have access to the required documentation. There are "Dear Physician" letters available on each DME MAC website to help in obtaining the required documentation.

70. **Q:** What documentation must accompany a claim for continued CPAP or Bi-Level therapy after a patient has failed the initial 90-day period and additional 30-day period.

**A:** Documentation requirements are outlined in the LCD and Policy Article. The supporting documentation must be kept on file and does not have to be submitted with the claim.

71. **Q:** What is Medicare's role in educating physicians about the detail of documentation Medicare expects to find in the patient's medical record to justify equipment or on-going use of supplies?

**A:** The DME MACs are required to and funded to educate the supplier community. Therefore, we only provide limited education to the physician community. However, the DME MACs are working with Part A and Part B Medicare contractors regarding physician education pertaining to documentation requirements affecting the supplier community. The suppliers are expected to help educate the physician community on the documentation requirements.
72. **Q:** How do you get the Medicare members to go to Pedorthic or DME facilities with a prescription and physician's documentation/medical necessity? Everyone comes in with only a prescription and would have to go back to get physician's documentation.

**A:** The DME MACs are required to and funded to educate the supplier community. Therefore, we only provide limited education to the physician community. The suppliers are expected to help educate the physician community on the documentation requirements necessity.

73. **Q:** What is being done to reduce offsets due to home health consolidated billing?

**A:** Home Health is given a timely filing limit similar to providers. Therefore, this issue cannot be corrected. It is up to the provider to be sure that their patient is not in a home health episode when supplying items to a beneficiary.

74. **Q:** What documentation is needed for intermittent use of inotropic drugs on an E0781 ambulatory infusion pump?

**A:** The documentation needed would be a written order, physician records pertaining to the information as outlined in the Local Coverage Determination (LCD) including the before and after inotropic drug infusion values, request for refill, and proof of delivery.

75. **Q:** Please explain exactly what types of documentation are required for each piece of equipment that you cover.

**A:** Suppliers must review the LCD regarding the type of equipment in question to determine what documentation is required. The documentation requirements in each LCD differ.

76. **Q:** How long will it take to get a determination on CERT audits? I am seeing overpayment determinations more than a year after the original audit documentation was submitted.

**A:** Most of the time there is a 60 day turn-around but during this report period the CERT contractor was re-reviewing the claims from the last report period so you may have seen results that were older than the normal timeframe.
77. Q: What is the average time it takes for negative pressure wound care claims to be paid?

A: Claims processing has a timeframe of up to 30 days for completion.

78. Q: Is there a way to retrieve information from Medicare regarding whether the beneficiary has another active supplier?

A: Suppliers may use the Interactive Voice Response Unit (IVR) or the Claims Status Inquiry (CSI) system to determine if a beneficiary has previously rented or purchased the same or a similar piece of equipment. This information will assist the supplier in determining whether the beneficiary is currently receiving the item from another supplier.

79. Q: Does the TENS unit rental and purchase apply to the patient maximum?

A: If you are referring to fee allowance, then no. There is no reduction in the allowed amount for purchase due to the two months rental.

81. Q: Please explain the KX modifier as applies to L4360 and other foot and ankle orthoses.

A: The ankle-foot/knee-ankle-foot orthosis policy does require use of the KX modifier when the requirements specified in the medical policy have been met. Refer to the Local Coverage Determination and Policy Article for specific coverage requirements.